Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VICTOR KUMAR-MISIR, MD
1718 EAST HEDGECROFT DRIVE
SEABROOK, TEXAS 77586-5836

Respondent Name

SEABRIGHT INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1024-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Service rendered. Payment denied."

Amount in Dispute: $865.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on December 07, 2010 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2010	99456-W5-NM, 99456-W8-RE, 99080-73-RR	$865.00	$850.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. Texas Labor Code Title 5, Subtitle A, Chapter Subchapter A, in §408.0041 provides general provisions for DD Examinations and carrier responsibilities for payment of such services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 04, 2010
   - 900 – PER ADJUSTER INSTRUCTION *DENY AS DISPUTED CLAIM:
   - UTL-M – UTILIZATION MANUAL ADJUSTMENT

Issues

1. Has the compensability issue been resolved?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is CPT code 99080-73 included in the payment for the Return to Work (RTW) examination?
4. Is the requestor entitled to additional reimbursement?

Findings

1. On the EOB dated October 04, 2010, the respondent denied reimbursement based upon "900 – PER ADJUSTER INSTRUCTION *DENY AS DISPUTED CLAIM:" A Contested Case Hearing was held on April 13, 2010 to decide whether claimant sustained a compensable injury on June 29, 2009 and if claimant sustained disability. The Decision and Order was in favor of compensability ruled April 21, 2010. There was no response to request for reconsideration, nor was there a response to MFDR filing of DWC-60, therefore, the disputed services will be reviewed. Texas Labor Code §408.0041 states in part (a)(1)(2)(5):

   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:

   (1) the impairment caused by the compensable injury;

   (2) the attainment of maximum medical improvement;

   (5) the ability of the employee to return to work; or

   Texas Labor Code §408.0041 states in (h)(1):

   (h) The insurance carrier shall pay for:

   (1) an examination required under Subsection (a) or (f).

   28 Texas Administrative Code §134.204 states in part (i)(1)(E):
   (E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W8"; and

   28 Texas Administrative Code §134.204 states in part (k):
   (k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.
2. Review of the documentation supports that the requestor determined that the injured worker (IW) was not at MMI, and the return to work as well as filled out required reports. The provider billed the amount of $865.00 for CPT code 99456-W5-NM the DD exam. The Maximum Allowable Reimbursement (MAR) is $350.00 per 28 Texas Administrative Code §134.204(j)(2)(A) and §134.204(j)(3)(C). In addition, CPT code 99456-W8-RE was billed for the ability for the IW to return to work (RTW) per §134.204(i)(2)(A) & (k) which has a MAR of $500.00.
3. Regarding CPT code 99080-73-RR, 28 Texas Administrative Code §134.204(k) states that the RTW reimbursement "shall include Division-required reports". Therefore, reimbursement is bundled and no separate reimbursement is due.

   Per the review of submitted documentation, the Division finds that the MAR for Division ordered services is $850.00. The requestor rendered the services ordered by the Division, and is therefore entitled to reimbursement as described above.

Conclusion

For the reasons stated above, the Division fins that the requestor has established that reimbursement is due. As a result, the amount ordered is $850.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 28, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.